Kay Bailey Hutchison, Chairman
Bill Hughes, Staff Director

347 Russell Senate Office Building
Washington, DC 20510
202-224-2946
http://rpc.senate.gov

SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 31 September 26, 2007

H.R. 976 - Children's Health Insurance Reauthorization Act of 2007 (with House Amendments)

On Wednesday, September 26, 2007, cloture was filed on the motion to concur with the House amendments to the Senate amendments to H.R. 976; pursuant to a unanimous consent agreement, the cloture motion was deemed to have been filed on Tuesday, September 25. The Senate will vote on the cloture motion on Thursday, September 27.

Noteworthy

- On Wednesday, September 26, the Majority Leader made a motion to concur with the House amendments to H.R. 976. He then filled the amendment tree and filed cloture on the motion to concur with the House amendments. The cloture motion was deemed to have been filed on Tuesday, September 25. A message from the House is privileged and there is no motion to proceed. On Thursday, September 27, the Senate will vote on the motion to invoke cloture on the motion to concur.

- H.R. 976 largely adopts the funding and policies in the Senate bill passed in August. This legislation is significantly different from the earlier House version (H.R. 3162).

- H.R. 976 reauthorizes the existing SCHIP program and provides an additional $34.9 billion over five years to increase enrollment, which is financed by raising the tobacco tax. Funding for the program will expire on September 30, 2007 if not reauthorized.

- H.R. 976 extends coverage for the 6.6 million children currently enrolled in SCHIP, as well as an additional 3.1 million currently uninsured children. Of these 3.1 currently uninsured children, 2.5 million are low-income and not currently enrolled in SCHIP or Medicaid. The additional 600,000 are covered by expanding coverage to new populations.

- The Administration has issued a Statement of Administration Policy indicating that the President will veto the legislation as written.

Background

In early August, the House and Senate each passed separate legislation reauthorizing and expanding the State Children's Health Insurance Program (SCHIP). In the Senate, the committee-reported SCHIP legislation, S. 1893, was substituted into a House small business tax bill, H.R. 976. The bill was passed on August 2, 2007 by a vote of 68-31 (Vote No. 307) and sent to the House. The House passed its own bill, H.R. 3162, on August 1 by a vote of 225-204 (Vote No. 787).

Conferees were not appointed to reach a conference agreement, but a bicameral compromise was reached. The compromise was first considered in the House as amendments to the Senate-passed version of H.R. 976. H.R. 976, as amended by the House, was passed by a vote of 265-169 (Vote No. 906) on September 26.

On Wednesday, September 26, the Majority Leader made a motion to concur with the House amendments to H.R. 976. He then filled the amendment tree and filed cloture on the motion to concur with the House amendments. Pursuant to a unanimous consent agreement, the cloture motion was deemed to have been filed on Tuesday, September 25. A message from the House is privileged and there is no motion to proceed. On Thursday, September 27, the Senate will vote on the motion to invoke cloture on the motion to concur.

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SCHIP was passed in 1997 to provide health care to low-income children under age 19 between 100-and 200-percent of Federal Poverty Level (FPL) (between $20,650 and $41,300 per year for a family of four in 2007).[1] Funding for the program will expire on September 30, 2007 if not reauthorized. A Continuing Resolution, which is being considered by Congress, is expected to provide funding for SCHIP at currently authorized levels through the expiration of the resolution on November 16, 2007.

H.R. 976 reauthorizes the existing SCHIP program and provides an additional $34.9 billion over five years to increase enrollment, which is financed through increases in the tobacco tax. States will be permitted to expand coverage to families earning up to 300 percent of FPL. States that had already expanded their programs above that amount, or that have submitted a plan to expand coverage, will be permitted to continue at the higher level. Financial incentives will be offered to states to encourage enrollment of low-income populations. States will be prohibited from expanding coverage to childless

[1] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.

adults and parents, and the legislation establishes a process for states that already enroll these populations to transition them to Medicaid. The legislation overturns the recent Center for Medicare and Medicaid Services (CMS) letter which imposed new requirements on crowd-out[2] and coverage of low-income children for those states that have expanded their coverage levels above 250 percent FPL.

States will have an option to cover low-income pregnant women under SCHIP. The bill allows states to use Social Security numbers rather than documentation to prove eligibility for Medicaid and SCHIP. The bill makes it easier for states to use premium assistance programs to enroll uninsured children on employer-sponsored plans. Finally, the bill allows "express lane" eligibility, and provides dental and mental health benefits to children insured under the program.

Highlights

Coverage Levels:

- H.R. 976 extends coverage for the 6.6 million children currently enrolled in SCHIP as well as 3.1 million children currently uninsured. Most of these increases come from providing coverage to children currently eligible for SCHIP or Medicaid but not enrolled: 2.5 million of the 3.1 million children are currently eligible or entitled to coverage, while 600,000 come from expanding coverage to higher income levels. Additionally, H.R. 976 provides funds to continue coverage of 700,000 children (included among the 6.6 million currently covered) who will otherwise lose eligibility under the baseline budget.
- H.R. 976 covers 200,000 fewer low-income children than the Senate bill. The number of children covered by expanding SCHIP eligibility is unchanged at 600,000. SCHIP outlays under H.R. 976 are approximately $1.5 billion less than under S. 1893, which partly accounts for the variation in the number of newly insured children between the bills.
- The crowd-out effect is slightly lower under H.R. 976 than the original Senate bill. Under H.R. 976, 1.6 million children on SCHIP will drop private coverage, while 1.7 million would drop private coverage under S. 1893. When added to changes in Medicaid coverage, 2.0 million children will drop private coverage as compared to 2.1 million under the Senate bill.
- For coverage of newly enrolled populations under SCHIP, the crowd-out effect remains 1 for 1. Specifically, while 600,000 uninsured children will be covered by expanding eligibility, 600,000 children who currently have private insurance will join the public program. This is unchanged from S. 1893.

[2] "Crowd-out" refers to the replacement of private insurance with public insurance.

Populations Covered:

- The SCHIP statute allows states to cover children with incomes up to 200 percent of FPL, or 50 percentage points above their Medicaid threshold. However, under current law, states have been able to disregard certain types of income in determining eligibility for the program.[3]
- States will be permitted to expand coverage to families earning up to 300 percent of FPL ($61,950 for a family of four in 2007) at the enhanced SCHIP matching rate. States that have an approved state plan amendment or that have passed a state law to cover children above 300 percent of FPL will be allowed to continue coverage at the higher eligibility level.[4]
- H.R. 976 contains similar prohibitions as the Senate bill regarding the approval or renewal of any state waivers providing coverage to childless non-pregnant adults. New waivers for parents and childless adults will be prohibited. States that currently have waivers to cover parents will receive a reduced match for coverage of parents. States will be required to meet certain child coverage benchmarks or have their funding further reduced to the Medicaid level.
- H.R. 976 retains incentives to states to increase enrollment of children below 200 percent of FPL in order to target low-income children currently eligible for Medicaid and SCHIP but not enrolled in the programs.
- Coverage is not expanded to individuals up to age 21, as under H.R. 3162.
- The legislation revises the citizenship documentation requirements established under the Deficit Reduction Act of 2005 (DRA) for individuals receiving SCHIP and Medicaid benefits. The DRA requires that citizens and nationals present documentation to prove citizenship in order for states to receive reimbursement for Medicaid and SCHIP services. Under this section, a state can submit the name and Social Security number of an applicant and meet the legal requirements for Medicaid reimbursement.

Funding:

- CBO estimates a total change in direct spending of $34.9 billion, which does not include $25 billion contained in the budget baseline needed to reauthorize the program. This amount is virtually unchanged from the Senate bill, and year-to-year allotments remain the same.
  The bill appropriates the following amounts for fiscal years 2008-2012:
  FY 2008: $9.125 billion.
  FY 2009: $10.675 billion.
  FY 2010: $11.85 billion.
  FY 2011: $13.75 billion.
  FY 2012: $ 1.75 billion for the period beginning October 1, 2011 and ending on March 31, 2012; and $1.75 billion for the period beginning April 1, 2012 and ending on September 30, 2012.

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[3] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[4] The legislation therefore retains an exception that appears designed to allow New York an opportunity to expand its eligibility level to 400-percent FPL.

- The legislation is paid for by increasing the federal excise tax on tobacco products. The federal excise tax on cigarettes will be increased by 61 cents and largely proportionate increases will be imposed on other tobacco products. This will increase revenues by $35.7 billion over five years (2008-2012) and $71 billion over 10 years (2008-2017).
- As with S. 1893, H.R. 976 is compliant with the Senate's "Pay-Go" rules as a five-year authorization. However, the legislation reduces the allotment in the fifth year in order to comply with "Pay-Go" over a 10-year window. According to CBO, SCHIP outlays are projected to go from $8.4 billion in 2012 to only $2.3 billion in 2013. CBO estimates that the total cost of the bill over the 2008-2017 period would be approximately $110 billion if program costs increase according to enrollment projections, which is significantly above the approximately $70 billion in revenues provided by the tobacco tax.

Noteworthy Provisions Changed from Senate Bill

Requirement that Programs Provide Dental Benefits:
Section 501 provides that health coverage provided under SCHIP must include dental benefits. States can choose a benefit that meets one of three benchmarks: 1) Coverage equivalent to the Federal Employees Health Benefits Program (FEHBP); 2) The plan selected most frequently by state employees; 3) The dental plan with the highest enrollment in the state.

Provision Addressing HHS Letter Limiting Expansion of SCHIP Unless States Meet Certain Benchmarks Regarding Low-Income Children:
Section 116 effectively serves to override a CMS letter issued August 17, 2007, which would require that states meet certain coverage benchmarks before expanding SCHIP eligibility above 250 percent FPL.[5] The legislation does this by creating a new requirement that the General Accounting Office (GAO) studies crowd-out and low-income coverage rates.

GAO is required within 18 months to report on state-level best practices regarding crowd-out and how to more accurately measure the rate of private and public coverage. This report will then become the basis for recommendations on best practices to reduce crowd-out and a uniform set of data-points to enable states to track crowd-out and coverage rates. Thereafter, states with SCHIP programs that cover children above 300-percent FPL must include with their state plan amendments a description of their efforts to address crowd-out. Additionally, after April 1, 2010, states that do not meet a target rate of coverage (which is the average of the 10 states with the highest percentage of health coverage for low-income children) could lose federal SCHIP matching payments.

[5] Section 116 includes findings that the provisions in the section "are the appropriate policies to address" the issue of crowd-out. This language appears designed to signal congressional intent that these provisions will supersede any contradictory regulations. The CMS letter is available at: http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.

Expansion of "Express Lane" Eligibility:
The Senate bill created a three-year demonstration program for 10 states for "Express Lane" determination of eligibility for Medicaid or SCHIP. H.R. 976 expands this to allow all states an option (time limited to five years) to use an Express Lane agency to make SCHIP eligibility determinations. Express Lane Eligibility works by establishing connections with programs that have similar income eligibility rules to Medicaid and SCHIP—such as Food Stamps, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and the National School Lunch Program (NSLP)—to find and more quickly enroll uninsured children in the health insurance programs. A state can provide for presumptive eligibility if an Express Lane agency determines that a child qualifies. If a state finds a child to be ineligible under the Express Lane procedures, the state will then be required to determine eligibility using its regular procedures.

Prohibition of Health Opportunity Account (HOA) Demonstration:
Sec. 613 prohibits the implementation of any Opportunity Health Account demonstrations. The Deficit Reduction Act of 2005 (P.L. No. 109-171) provides for 10 States to operate Medicaid demonstration programs to test alternative systems to deliver Medicaid benefits through an HOA in combination with a high-deductible health plan. H.R. 976 prohibits the approval of any new demonstration programs.

Changes to Funding Formula and Redistribution of Unused Allotments:
Sections 104-106 revise the allotment and redistribution formula from the formula in S. 1893. The Senate bill relied on a state's projected estimate to set each state's allotment. H.R. 976 instead looks at actual prior-year spending, grown by a standard inflation factor, which is then reassessed every two years. The impact of these changes is very state specific.

Sense of the Senate Regarding Access to Affordable and Meaningful Health Insurance Coverage:
Affirms Congressional intent to enact legislation this year that will improve access to affordable and meaningful health insurance for individuals and employees of small businesses. The bill states that this can be done through facilitating risk pooling mechanisms or by providing "financial assistance and tax incentives for the purchase of private insurance coverage."

Support for Injured Service Members and Military Family Job Protection:
Sections 621 and 622 provide leave for family members to care for an injured service member. Specifically, section 621 provides 26 weeks of leave during a 12-month period for a spouse, child, parent, or next of kin to care for a service member by expanding the Family and Medical Leave Act (FMLA). FMLA already provides 12 weeks of medical leave for a parent, spouse, or child to provide care for an injured service member. Section 622 amends the Uniformed Service Employment and Reemployment Rights Act (USERRA) to ensure that no family member of a recovering service member can be denied retention in employment, promotion, or any other benefit of employment by their mployer for a period of up to 52 weeks as a result of their absence.

The two sections are the result of two amendments to the Senate bill and reflect the recommendation by the President's Commission on Care for America's Wounded

Warriors. Concern has been expressed that, when combined, the provisions are inconsistent and overlap as they amend both FMLA and USERRA. Concern has also been noted regarding the bill's expansion of FMLA, a statute with documented flaws in its implementation. Critics argue that FMLA should not be expanded until the flaws are addressed.

Earmarks in H.R. 976: S. 1893 did not contain any earmarks. H.R. 976, however, contains a number of special-interest provisions unrelated to children's health care:

- Section 615: Amends the calculation of Medicaid reimbursement (the FMAP rate) to exclude "a significantly disproportionate employer pension and insurance fund contribution." This appears designed to prevent the inclusion of a recent payment by General Motors (GM) into its pension fund. GM recently made a relatively large contribution to its pension plans ($15 billion), causing Michigan's per-capita income calculation to increase. Federal reimbursements for Medicaid and SCHIP are calculated based on a state's per-capita income; the higher a state's income, the lower its reimbursement from the federal government. The earmark disregards the GM pension contribution, thereby lowering Michigan's per-capita income and raising its federal reimbursement level. CBO estimates that this will cost $500 million for FYs 2008-12, and $1.2 billion for FYs 2008-17.
- Section 617: Changes the Disproportionate Share Hospital (DSH) allotments for Tennessee and Hawaii. CBO estimates that the provision will cost $200 million for FYs 2008-12, and $400 million for FYs 2008-17.
- Section 618: Funding for Memphis Regional Medical Center. CBO's score did not show a cost.

Administration Position

The Administration issued a veto threat on H.R. 976.[6] The Statement of Administration Policy on H.R. 976 says that, "The Administration strongly supports reauthorization of the State Children's Health Insurance Program (SCHIP) which maintains SCHIP's original purpose of targeting health care dollars to low-income children who need them most. However, the current bill goes too far toward federalizing health care and turns a program meant to help low-income children into one that covers children in some households with incomes of up to $83,000 a year. If H.R. 976 were presented to the President in its current form, he would veto the bill. It is urgent that Congress complete its work and send the President a bill he can sign before the program expires September 30, 2007, or at a minimum to pass a clean, temporary extension of the current SCHIP program that he can sign by September 30th."

[6] Available at: http://www.whitehouse.gov/omb/legislative/sap/110-1/hr976sap-h2.pdf.